MEDICARE+CHOICE ORGANIZATION
OPTIONAL HEART FAILURE DATA COLLECTION TOOL

ABSTRACTION INSTRUCTIONS

Revised September 17, 2001

This tool is a modified version of the the Medicare+Choice Organization Optional Heart Failure Data Collection Tool designed by CMS and the National Heart Failure CASPRO. With this revised tool, a user can abstract both QAPI and Extra Payment concurrently for a given case. This modified tool does not eliminate the need for double abstraction (i.e., two sets of questions) if the EP and QAPI time periods are not identical, but it does allow for side-by-side EP and QAPI abstraction inside one case. Users should begin by answering the project variable located in the first section. The project choices are QAPI, Extra Payment 2001, and Extra Payment 2002, and all choices come with the option of including or excluding the optional QIs (ACEI dosage, medication prevalence, and NYHA class). After answering the project question, sections will direct the user to only abstract those variables related to the project options chosen. A user who is not interested in optional QI data may prefer this tool to the original, as the original tool requires a user answer all Optional QI questions (using 'Not Collecting' options, as applicable), regardless of interest. PROs are encouraged to customize the tool further if desired, however, this may or may not warrant changes to the analyzer. The original version of the tool is completely functional and may still be used if desired. These instructions are to be used with the corresponding “MEDICARE+CHOICE ORGANIZATION OPTIONAL HEART FAILURE DATA COLLECTION TOOL - DATA COLLECTION FORM”, revised September 17, 2001.

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These instructions are composed of several fields:

- Data Element: A very brief descriptive title for the question being asked.
- Question: The essential question to be answered by the abstractor when reviewing the medical chart(s).
- Chart Abstraction Instructions: Abstraction guidelines designed to aid the abstractor in answering the question based on chart documentation. Reference the 'Inclusions' section to find additional terminology for terms used.
- Recommended Chart Locations: The sources in the inpatient and/or outpatient chart(s) where the information for that particular data element is most frequently found. An abstractor is NOT limited to these sources when answering a question.
- Inclusions: Additional terminology (synonyms, like conditions) for select terms used in the 'Chart Abstraction Instructions' section. Because documentation varies greatly, due to such factors as a clinician's personal writing style, clinician experience, administration policy and procedure, and even regional differences, these lists include only the most frequently documented terms and cannot be made to be all-inclusive. An abstractor will need to use his/her best judgment to determine terminology synonymous with inclusion list terms or conditions which should be included. This field may also be used for medication class look-up lists.
- Exclusions: Terminology or conditions which should not be considered inclusions for select terms used in the 'Chart Abstraction Instructions' section. Again, lists cannot be made to be all-inclusive, and are limited to those terms/conditions which the abstractor most often might question when considering whether a term/condition should or should not be included. When there is documentation of both an inclusion and exclusion (or synonymous terms/conditions thereof), or in any case where there is conflicting documentation which equally supports both a 'Yes' and 'No' answer, the abstractor should select 'Yes', unless otherwise instructed.
- Recommended Data Sources Other Than Charts: Additional data sources which may be helpful in project data collection. M+COs are NOT limited to the supplemental data sources listed and may use **any reviewable data source**, such as billing, enrollment, administrative, laboratory, and/or pharmacy databases, to supplement chart-abstracted data. The ICD-9-CM and CPT code listings provided in these sections are year 2001 only. To most effectively use other billing data, new code lists for other years should be constructed by the M+CO as needed to ensure the accuracy of codes included. Narrative descriptions for these codes may be found in attachment A at the end of this document.

IMPORTANT NOTES:

- There are optional data elements, skip patterns, and one potential stop abstraction point in this tool. For those optional elements that a project chooses to not collect data, the tool provides "Not Collecting" options. Blanks should only appear when directed by a skip pattern or stop abstraction point, or when entire sections are exempt from abstraction because of the choices marked in the project question (the place on the data collection form where a user chooses for which project(s) they are abstracting a given case - e.g., QAPI, EP2001, QAPI and EP2001). When using paper tool format, it is strongly recommended that when the abstractor finishes abstracting a case, he/she should take a moment to look back through the form to make sure all questions are completed as appropriate.
- The LVF assessment test ICD-9-CM and CPT codes listed are suggestions only. Their presence/absence may not necessarily identify people who have or have not had an LVF assessment test. It is up to the M+CO to decide which codes, if any, they would like to use to help them identify people with left ventricular systolic dysfunction.
- The physician encounter CPT codes listed in attachment B and the NDC listings (mcohf_ndc_list.xls) are provided as helpful guides in sampling (for QAPI measurement) and pharmaceutical database querying, respectively. These are only suggestions which the M+CO may or may not consider using.

MEDICARE+CHOICE ORGANIZATION OPTIONAL HEART FAILURE DATA COLLECTION TOOL: ABSTRACTION INSTRUCTIONS

DEMOGRAPHICS/EXCLUSION/MISCELLANEOUS

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
1. First name	Patient's first name	Enter the first name.	none	none	none	none
2. Last name	Patient's last name	Enter the last name.	none	none	none	none
3. HIC #	What is the patient's HIC #?	Enter the patient's Medicare/HIC number. *Include any appropriate alpha characters.* *Omit hyphens or other punctuation.* *If unable to determine, enter "X".*	Outpatient chart: • billing information/ insurance page • face sheet Inpatient chart: • face sheet	none	none	none
4. Social security #	What is the patient's social security number?	Enter the patient's social security number. *Omit hyphens or other punctuation.* *If unable to determine, enter "X".*	Outpatient chart: • billing information/ insurance page • face sheet Inpatient chart: • face sheet	none	none	none
5. Date of birth	What is the patient's date of birth?	Enter the patient's birth date in MM/DD/YYYY format. *If unable to determine, enter "X".*	Outpatient chart: • billing information/ insurance page • face sheet • test reports Inpatient chart: • face sheet	none	none	none
6. Practice # / Provider #	What is the practice or provider identification number?	Enter the practice or provider identification number as directed. *If unable to determine or if not gathering this information at this time, enter "X".*	none	none	none	none

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
7. Medicare+ Choice Organization contract #	What is the Medicare+ Choice Organization contract number?	Enter the Medicare+Choice Organization contract practice number as directed. *If unable to determine or if not gathering this information at this time, enter "X".*	none	none	none	none
8. Renal dialysis	Is there documentation that the patient was on renal dialysis anytime during the following timeperiods?	Indicate whether the patient was on renal dialysis anytime during the time periods listed. Only those time periods associated with the choices marked for the project question ("Project(s) for which this case is being abstracted") need to be reviewed. ***Select all that apply.*** ➢ **M+CO-designated QAPI time period** ➢ **EP 2001 reporting time period** ➢ **EP 2002 reporting time period** ➢ **None of the above** **=> IF ALL TIME PERIODS ASSOCIATED WITH THE CHOICES SELECTED FOR THE PROJECT QUESTION ARE MARKED, STOP ABSTRACTION**	Outpatient chart: • consultation reports • dialysis treatment records • problem list • progress notes Inpatient chart: • consultation reports • dialysis treatment records • discharge summary • history & physical • progress notes	**Renal dialysis** • continuous ambulatory peritoneal dialysis (CAPD) • hemodialysis (HD) • peritoneal dialysis • renal dialysis		Billing data: ICD-9-CM codes - V56.0, V56.8, 39.95, 54.98; CPT codes - 90935, 90937, 90940, 90945, 90947, 90989, 90993 (See attachment A for narrative descriptions of these codes)
9. OPTIONAL: M+CO-defined field #1		This element is optional and may be used to collect additional demographics, patient identification information or other data. Examples - medical record #, insurance #, additional practice/provider #s, information on the record(s) used for abstraction. Abstract this variable as directed. *If not utilizing this field at this time, enter "X".*				
10. OPTIONAL: M+CO-defined field #2		This element is optional and may be used to collect additional demographics, patient identification information or other data. Examples - medical record #, insurance #, additional practice/provider #s, information on the record(s) used for abstraction. Abstract this variable as directed. *If not utilizing this field at this time, enter "X".*				
11. OPTIONAL: M+CO-defined field #3		This element is optional and may be used to collect additional demographics, patient identification information or other data. Examples - medical record #, insurance #, additional practice/provider #s, information on the record(s) used for abstraction. Abstract this variable as directed. *If not utilizing this field at this time, enter "X".*				

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS

QAPI - LVF AND ACE QIs *(Complete only if option 'QAPI QIs, no optional QIs' or 'QAPI QIs with optional QIs' is among the choices marked in the project question.)*

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
12. LVF assessment	Is there documentation that left ventricular function (LVF) was assessed **anytime** before or during the M+CO-designated QAPI time period?	Indicate whether there is documentation that LVF was assessed ANYTIME before or during the M+CO-designated QAPI time period, in any setting. *LVF may be presumed to be previously assessed if one or more of the following is present:* 1) *A formal report from one of the following diagnostic tests: echocardiogram (echo), MUGA scan, or cardiac catheterization - left ventriculogram (LV gram), OR* 2) *Physician/nurse practitioner/physician assistant reference to one of the above diagnostic tests, OR* 3) *Physician/nurse practitioner/physician assistant notation of LVF, either as an ejection fraction (EF) or a narrative qualitative description (Examples - "moderate left ventricular systolic dysfunction", "known systolic dysfunction") without reference to an actual assessment test* *Disregard references to LVF assessment tests when a test was ordered or planned but documentation does not indicate that it was actually **done** before or during the M+CO-designated QAPI time period* **=> IF NO/UNABLE TO DETERMINE, SKIP TO #14**	Outpatient chart: • consultation reports • diagnostic test reports • problem list • progress notes Inpatient chart: • consultation reports • diagnostic test reports • discharge summary • history & physical	**Echocardiogram (echo)** • 2-D • cardiac ultrasound • Doppler color flow mapping • M-mode **MUGA (multiple gated acquisition scan)** • cardiac blood pool imaging • Cardiolite scan • gated blood pool imaging study • gated heart study • gated ventriculogram • radionuclide ventriculography • Sustamibi scan • technetiuim scan • thallium stress test with LVEF • wall motion study **Cardiac catheterization – Left ventriculogram (LV gram)** • Cardiac angiography - left ventriculogram (LV gram) **Left ventricular function (LVF)** • akinesis • contractility • diastolic dysfunction • diastolic function • diastolic impairment • dyskinesis • ejection fraction (EF) • hypokinesis • left ventricular diastolic dysfunction • left ventricular diastolic function • left ventricular dysfunction (LVD) • left ventricular ejection fraction (LVEF) • left ventricular systolic dysfunction (LVSD) • systolic dysfunction • systolic function • history or finding of left ventricular function (or any of the other above inclusions) described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely",	**Left ventricular function (LVF)** • history or finding of left ventricular function (or any of the other LVF inclusive terms) described as "possible" or "questionable" • left ventricular compliance • left ventricular hypertrophy (LVH)	Billing data: Tests **likely** to represent LVF assessment tests: ICD-9-CM code - 88.72; CPT codes - 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350 (See attachment A for narrative descriptions of these codes) Tests which **possibly** represent LVF assessment tests: ICD-9-CM codes - 88.5x, 92.05; CPT code - 78414 (See attachment A for narrative descriptions of these codes)

				“probable”, or “suggestive of”		

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
13. LVSD	Before or during the M+CO-designated QAPI time period, is the **most recent** available LVF documented as an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction (LVSD)?	Indicate whether the **most recent** LVF available is documented as an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction (LVSD). Use only documentation before or during the M+CO-designated QAPI time period to ascertain this information. *Numeric EFs:* ♦ *The value may be documented as a percentage (%), whole number, or decimal. Convert all decimals to percentages (example - 0.40 = 40). Value should be between 5 and 80.* ♦ *If the EF is documented as less than (<) or greater than (>) a given number, use the value one whole number below or above the given number. Examples - "EF < 40%" Use 39%, "EF > 40%" Use 41%* ♦ *If the EF is not documented as a whole number, round fractions to the nearest whole number (examples - 39.5% = 40%, 39.4% = 39%).* ♦ *If both calculated and estimated values are documented on an LVF assessment test report, use the calculated value.* ♦ *If the EF is documented as a range, use the midpoint and consider this an estimated value. Example - LVEF of "35-45%". Use 40% as an estimated EF value.* *LVFs (numeric EFs or narrative descriptions of LVF):* ♦ *When using LVF assessment test reports or physician/nurse practitioner/physician assistant references to test results:* ▪ *If there is more than one test on the same date, use the following priority order in determining the LVF:* *1. MUGA* *2. echocardiogram* *3. cardiac catheterization* *4. progress notes*	Outpatient chart: • consultation reports • diagnostic test reports • problem list • progress notes Inpatient chart: • consultation reports • diagnostic test reports • discharge summary • history & physical	**Ejection fraction (EF)** • left ventricular ejection fraction (LVEF) **Left ventricular function (LVF)** • akinesis • contractility • diastolic dysfunction • diastolic function • diastolic impairment • dyskinesis • ejection fraction (EF) • hypokinesis • left ventricular diastolic dysfunction • left ventricular diastolic function • left ventricular dysfunction (LVD) • left ventricular ejection fraction (LVEF) • left ventricular systolic dysfunction (LVSD) • systolic dysfunction • systolic function • history or finding of left ventricular function (or any of the other above inclusions) described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of" **Moderate or severe left ventricular systolic dysfunction (LVSD)** • contractility described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • ejection fraction (EF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • hypokinesis described as diffuse, generalized, or global • left ventricular dysfunction (LVD) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not	**Left ventricular function (LVF)** • history or finding of left ventricular function (or any of the other LVF inclusive terms) described as "possible" or "questionable" • left ventricular compliance • left ventricular hypertrophy (LVH) **Moderate or severe left ventricular systolic dysfunction (LVSD)** • history or finding of moderate or severe left ventricular systolic dysfunction (or any of the other moderate or severe LVSD inclusive terms) described as "possible" or "questionable"	none

		▪ *If two or more LVFs are documented in reference to the same test, select 'Yes' if any of the documented LVFs is an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction.* ♦ *When using only physician/nurse practitioner/physician assistant notations of LVF without reference to actual assessment tests:* ▪ *If unable to determine the most recent LVF between two or more LVFs, select 'Yes' if any of the documented LVFs is an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction.* ♦ *If unable to determine the most recent LVF between an LVF from an LVF assessment test report and an LVF noted by a physician/nurse practitioner/physician assistant without reference to an actual assessment test, use the value/description from the LVF assessment test report.*		specified • left ventricular ejection fraction (LVEF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • left ventricular function (LVF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • left ventricular systolic dysfunction (LVSD) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not specified • systolic dysfunction described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not specified • systolic function described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • history or finding of moderate or severe left ventricular systolic dysfunction (or any of the other above inclusions) described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of"		

IMPORTANT NOTES:

- This ACE inhibitor question has been designed to allow M+COs to collect ACEI information on all patients. If ACEI information is to be collected ONLY for patients with LVSD, defined as cases where question #13 = Yes, the option 'Not collecting' should be selected for question #14 when the patient does NOT have documented LVSD (question #12 = No/Unable to determine or question #13 = No/Unable to determine). FOR QUESTION #14, THE OPTION 'NOT COLLECTING' SHOULD NEVER BE USED IN CASES WHERE THE PATIENT HAS LVSD (QUESTION #13 = YES).
- The analyzer accompanying this tool will calculate the ACEI quality indicator only for patients with LVSD. If M+COs wish to evaluate ACEI use in patients without LVSD, they will need to modify the analyzer accordingly.

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
14. ACEI prescribed	Was an ACE inhibitor (ACEI) prescribed anytime during the M+CO-designated QAPI time period?	Indicate whether an ACEI was prescribed for the patient anytime during the M+CO-designated QAPI time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the M+CO-designated QAPI time period. If a separate list is not available, or medications on the list are not connectable to the M+CO-designated QAPI time period, review progress notes and consultation reports sequentially, starting from the last visit during the M+CO-designated QAPI time period and progressing backward as needed until the first visit of the M+CO-designated QAPI time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use ACEIs from earlier notes or reports within the M+CO-designated QAPI time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the M+CO-designated QAPI time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization.* => If ACEI information is to be collected ONLY for patients with LVSD, defined as cases where question #13 = Yes, select 'Not collecting' when the patient does NOT have documented LVSD (question #12 = No/Unable to determine or question #13 = No/Unable to determine) and **SKIP TO #21** NOTE: THE OPTION 'NOT COLLECTING' SHOULD NEVER BE USED IN CASES WHERE THE PATIENT HAS LVSD (QUESTION #13 = YES). **=> IF YES, SKIP TO #18**	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**ACEIs** See list in question #18 on data collection form	**ACEIs** • ACEIs given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
15. Contraindications to ACEI	If an ACEI was not prescribed during the M+CO-designated QAPI time period, is there documentation of one or more of the following?	If an ACEI was not prescribed during the M+CO-designated QAPI time period, indicate whether there is documentation of one or more of the listed conditions. Start with the latest available documentation during the M+CO-designated QAPI time period and progress backward. These conditions do NOT have to be cited as specific reasons for not prescribing an ACEI. ➢ **a. History of severe ACEI allergy (angioedema, hives, or severe rash) documented anytime before or during the M+CO-designated QAPI time period** ➢ **b. Aortic stenosis documented anytime before or during the M+CO-designated QAPI time period** ♦ *If conflicting information exists between diagnostic test reports and other physician sources, use the diagnostic test reports.* ➢ **c. Renal artery stenosis documented anytime before or during the M+CO-designated QAPI time period** ➢ **d. Serum potassium level > 5.5 mg/dl documented on three or more separate occasions during the M+CO-designated QAPI time period (excluding lab values measured during an acute care admission, an observation unit stay, or an emergency room visit)** ♦ *If the unit of measure is not documented for a given value, presume the unit of measure is mg/dl.* ♦ *Disregard a serum potassium value when documentation indicates it was measured during an acute care admission, an observation unit stay, or an emergency room visit.* ➢ **e. Serum creatinine level > 3.0 mg/dl documented on three or more separate occasions during the**	Outpatient chart: • consultation reports • diagnostic test reports (examples - echocardiogram, cardiac catheterization) • laboratory reports • medication list • problem list • progress notes • vital sign records Inpatient chart: • consultation reports • diagnostic test reports (examples - echocardiogram, cardiac catheterization) • discharge summary • history & physical • progress notes	**ACEIs** See list in question #18 on data collection form **Aortic stenosis (AS)** • aortic stenosis described as "borderline" • history or finding of aortic stenosis described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of" • aortic valve area of < 1.0 square cm **Renal artery stenosis** • renal artery stenosis described as "borderline" • history or finding of renal artery stenosis described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of" **Clinical trials** • CHARM • Elite • Elite II • Elite II with losartan • OVERTURE • ValHeFT	**Aortic stenosis (AS)** • aortic insufficiency only • aortic regurgitation only • aortic stenosis described as "insignificant" or "trivial" • history or finding of aortic stenosis described as "possible" or "questionable" • subaortic stenosis **Renal artery stenosis** • renal artery stenosis described as "insignificant" or "trivial" • history or finding of renal artery stenosis described as "possible" or "questionable"	Billing data: Aortic stenosis: ICD-9-CM codes - 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22 (See attachment A for narrative descriptions of these codes) Renal artery stenosis: ICD-9-CM code - 440.1 (See attachment A for narrative description of this code)

		M+CO-designated QAPI time period (excluding lab values measured during an acute care admission, an observation unit stay, or an emergency room visit) ♦ *Creatinine clearance measurements are not synonymous with serum creatinine measurements.* ♦ *If the unit of measure is not documented for a given value, presume the unit of measure is mg/dl.* ♦ *Disregard a serum creatinine value when documentation indicates it was measured during an acute care admission, an observation unit stay, or an emergency room visit.* ➢ **f. Systolic BP < 80 mmHg documented on three or more separate occasions anytime during the M+CO-designated QAPI time period (excluding blood pressures measured during an acute care admission, an observation unit stay, or an emergency room visit)** ♦ *Disregard patient-reported BPs.* ♦ *If the unit of measure is not documented for a given value, presume the unit of measure is mmHg.* ♦ *Disregard a blood pressure value when documentation indicates it was measured during an acute care admission, an observation unit stay, or an emergency room visit.* ➢ **g. Participation in a clinical trial testing alternatives to ACEIs as first-line heart failure therapy documented during the M+CO-designated QAPI time period** **=> IF YES, SKIP TO #21**				

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
16. Reason(s) no ACEI prescribed	In documentation before or during the M+CO-designated QAPI time period, did a physician/nurse practitioner/physician assistant give a reason at anytime for not prescribing an ACEI?	In documentation before or during the M+CO-designated QAPI time period, indicate whether a physician/nurse practitioner/physician assistant at anytime stated a reason for not prescribing an ACEI. *Examples:* *- "Pt. hypotensive. Will hold off on ACE therapy."* *- "Hx cough with ACEIs."* *- "BPs running low. Won't start ACE inhibitors now."* *- "Acute renal failure. ACEI therapy contraindicated."* *- "Hyperkalemia. Will start ACEIs when K+ drops."* *- "Pt. refuses ACE inhibitor treatment."* *Reasons for not prescribing an ACEI may be explicitly documented (example -"No ACEIs at this time - Creatinine 2.5") or implicitly suggested (example - "High K+ with ACEs in past."). If reasons are not mentioned in the context of ACEIs, do not make inferences.* *If an ACEI is discontinued before the M+CO-designated QAPI time period and a reason is documented for discontinuing the ACEI (example - "c/o severe cough Will dc Vasotec"), this should be construed as documentation of a reason for not prescribing an ACEI..* *Documentation which indicates consideration (example - "May start ACE therapy after BP stabilizes") should be construed as documentation of a reason for not prescribing an ACEI.* *Include nonspecific documentation of reasons (examples - "Problems with ACEs in past", "ACEIs contraindicated", "Intolerant of ACE inhibitors")* **=> IF NO/UNABLE TO DETERMINE, SKIP TO #21**	Outpatient chart: • consultation reports • medication list • problem list • progress notes Inpatient chart: • consultation reports • discharge summary • history & physical • progress notes	none	none	none
17. OPTIONAL: Other reason - Specify	In documentation before or during the M+CO-designated QAPI time period, what reason(s) does the physician/nurse practitioner/physician assistant give for not prescribing an ACEI?	Specify the physician/nurse practitioner/ physician assistant reasons documented before or during the M+CO-designated QAPI time period for not prescribing an ACEI. *If not gathering this information at this time, enter "X".* **=> SKIP TO #21**	Outpatient chart: • consultation reports • medication list • problem list • progress notes Inpatient chart: • consultation reports • discharge summary • history & physical • progress notes	none	none	none

QAPI - OPTIONAL QIs *(Complete only if option 'QAPI QIs with optional QIs' is among the choices marked in the project question. Follow direction of skip patterns in above section.)*

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
18. OPTIONAL: ACEI name	What is the name of the ACEI prescribed during the M+CO-designated QAPI time period?	Select the ACEI prescribed during the M+CO-designated QAPI time period. *If available documentation indicates that two or more different ACEIs were prescribed during the M+CO-designated QAPI time period, select the most recent one.* *If two or more ACEIs are prescribed concurrently, select the one ACEI by alphabetical order.* *If not gathering this information at this time, select 'Not collecting'.* **=> IF OTHER, COMPLETE #19** **=> IF UNABLE TO DETERMINE OR IF NOT GATHERING THIS INFORMATION AT THIS TIME, SKIP TO #21**	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	none	**ACEIs** • ACEIs given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)
19. OPTIONAL: ACEI - Other name	What is the other ACEI most recently prescribed during the M+CO-designated QAPI time period?	Specify the name of the other ACEI which, according to available documentation, was most recently prescribed during M+CO-designated QAPI time period.	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment		**ACEIs** • ACEIs given only during a hospitalization	pharmacy database

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
20. OPTIONAL: ACEI dosage	What is the TOTAL DAILY DOSAGE in mgs. of the ACEI identified in #18 (or #19) during the M+CO-designated QAPI time period?	Calculate the TOTAL DAILY DOSAGE in mgs. of the ACEI identified in #18 (or #19) during the M+CO-designated QAPI time period. *If the dosage of the ACEI changed during the M+CO-designated QAPI time period, calculate the total daily dosage from the most recent dosage documented in the available data sources.* *Do not use decimal points. Round fractions to the nearest whole number (example - captopril 6.25 mg bid. Total daily dosage = 12.50 mg. Enter 13 mg.).* *If unable to determine the total daily dosage of ACEI, enter "0".* *If not gathering this information at this time, enter "X".* *<u>ACEIs combined with other drugs:x</u>* *When combination medications are prescribed, the amount of ACEI these drugs contain is often not readily apparent. Dosages may be expressed as a name alone (example – "Prinzide, 1 tab") or a name followed by a pair of numbers (examples – "Lotrel 2.5/15, 1 tab", "Vaseretic 5-12.5, 2 tabs"). In calculating the ACEI total daily dosage, use the following alphabetized listings to ascertain the amount of the ACEI in ONE tablet of these combination medications:* *Accuretic 10/12.5, Accuretic 10-12.5 = 10 mg (quinapril)* *Accuretic 20/12.5, Accuretic 20-12.5 = 20 mg (quinapril)* *Accuretic 20/25, Accuretic 20-25 = 20 mg (quinapril)* *Capozide 25/15, Capozide 25-15 = 25 mg (captopril)* *Capozide 50/15, Capozide 50-15 = 50 mg (captopril)* *Lexxel = 5 mg (enalapril)* *Lotensin HCT 5/6.25, Lotensin HCT 5-6.25 = 5 mg (benazepril)* *Lotensin HCT 10/12.5, Lotensin HCT 10-12.5 = 10 mg (benazepril)* *Lotensin HCT 20/12.5, Lotensin HCT 20-12.5 = 20 mg (benazepril)* *Lotensin HCT 20/25, Lotensin HCT 20-25 = 20 mg (benazepril)* *Lotrel 2.5/10, Lotrel 2.5-10 = 10 mg (benazepril)* *Lotrel 5/10, Lotrel 5-10 = 10 mg (benazepril)* *Lotrel 5/20, Lotrel 5-20 = 20 mg (benazepril)* *Monopril HCT 10/12.5, Monopril HCT 10-12.5 = 10 mg (fosinopril)* *Monopril HCT 20/12.5, Monopril HCT 20-12.5 = 20 mg (fosinopril)* *Prinzide = 20 mg (lisinopril)* *Tarka 1/240, Tarka 1-240 = 1 mg (trandolapril)* *Tarka 2/180, Tarka 2-180 = 2 mg (trandolapril)* *Tarka 2/240, Tarka 2-240 = 2 mg (trandolapril)* *Tarka 4/240, Tarka 4-240 = 4 mg (trandolapril)* *Teczem = 5 mg (enalapril)* *Uniretic 7.5/12.5, Uniretic 7.5-12.5 = 7.5 mg (moexipril)* *Uniretic 15/25, Uniretic 15-25 = 15 mg (moexipril)* *Vaseretic 5/12.5, Vaseretic 5-12.5 = 5 mg (captopril)* *Vaseretic 10/25, Vaseretic 10-25 = 10 mg (captopril)* *Zestoretic = 20 mg (lisinopril)*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	none	**ACEIs** • ACEIs given only during a hospitalization	pharmacy database

IMPORTANT NOTES:

- The medication prevalence questions in this section have been designed to allow M+COs to collect medication prevalence information on all patients. If this information is to be collected ONLY for patients with LVSD, defined as cases where question #13 = Yes, the option 'Not collecting' should be selected for questions #21 - 25 when the patient does NOT have documented LVSD (question #12 = No/Unable to determine or question #13 = No/Unable to determine). The option 'Not collecting' should also be selected if an M+CO is not collecting this information on any patients.
- The analyzer accompanying this tool will calculate the medication prevalence measures only for patients with LVSD. If M+COs wish to evaluate medication prevalence in patients without LVSD, they will need to modify the analyzer accordingly.

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
21. OPTIONAL: Oral beta blocker prescribed	Was an oral beta blocker prescribed anytime during the M+CO-designated QAPI time period?	Indicate whether an oral beta blocker was prescribed for the patient anytime during the M+CO-designated QAPI time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the M+CO-designated QAPI time period. If a separate list is not available, or medications on the list are not connectable to the M+CO-designated QAPI time period, review progress notes and consultation reports sequentially, starting from the last visit during the M+CO-designated QAPI time period and progressing backward as needed until the first visit of the M+CO-designated QAPI time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use oral beta blockers from earlier notes or reports within the M+CO-designated QAPI time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the M+CO-designated QAPI time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization.* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**Oral beta blockers** See list on data collection form	**Oral beta blockers** • Oral beta blockers given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
22. OPTIONAL: Digoxin prescribed	Was digoxin prescribed anytime during the M+CO-designated QAPI time period?	Indicate whether digoxin was prescribed for the patient anytime during the M+CO-designated QAPI time period. *Outpatient chart:* *If available, use the separate medication list included in the chart.. Medications on the list must be dated or otherwise connectable to the M+CO-designated QAPI time period. If a separate list is not available, or medications on the list are not connectable to the M+CO-designated QAPI time period, review progress notes and consultation reports sequentially, starting from the last visit during the M+CO-designated QAPI time period and progressing backward as needed until the first visit of the M+CO-designated QAPI time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use digoxin from earlier notes or reports within the M+CO-designated QAPI time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the M+CO-designated QAPI time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization* *In lieu of documentation of digoxin prescription, if there is documentation that digoxin blood levels were drawn anytime during the M+CO-designated QAPI time period, digoxin prescription may be inferred.* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • laboratory reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • laboratory reports • nursing admission assessment	**Digoxin** See list on data collection form	**Digoxin** • Digoxin given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)
23. OPTIONAL: Spironolactone prescribed	Was spironolactone prescribed anytime during the M+CO-designated QAPI time period?	Indicate whether spironolactone was prescribed for the patient anytime during the M+CO-designated QAPI time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the M+CO-designated QAPI time period. If a separate list is not available, or medications on the list are not connectable to the M+CO-designated QAPI time period, review progress notes and consultation reports sequentially, starting from the last visit during the M+CO-designated QAPI time period and progressing backward as needed until*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**Spironolactone** • Aldactazide • Aldactone • Spironolactone Plus	**Spirronolactone** • Spironolactone given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
		the first visit of the M+CO-designated QAPI time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use spironolactone from earlier notes or reports within the M+CO-designated QAPI time period, regardless of whether they were subsequently discontinued. *Inpatient chart:* *For hospitalizations during the M+CO-designated QAPI time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization* *Select 'Not collecting' if not gathering this information at this time.*				
24. OPTIONAL: ARB prescribed	Was an angiotensin II receptor blocker (ARB) prescribed anytime during the M+CO-designated QAPI time period?	Indicate whether an ARB was prescribed for the patient anytime during the M+CO-designated QAPI time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the M+CO-designated QAPI time period. If a separate list is not available, or medications on the list are not connectable to the M+CO-designated QAPI time period, review progress notes and consultation reports sequentially, starting from the last visit during the M+CO-designated QAPI time period and progressing backward as needed until the first visit of the M+CO-designated QAPI time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use ARBs from earlier notes or reports within the M+CO-designated QAPI time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the M+CO-designated QAPI time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**ARBs** See list on data collection form	**ARBs** • ARBs given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
25. OPTIONAL: Long-acting nitrates/ hydralazine prescribed	Were BOTH long-acting nitrates AND hydralazine prescribed TOGETHER anytime during the M+CO-designated QAPI time period?	Indicate whether BOTH long-acting nitrates AND hydralazine were prescribed TOGETHER for the patient anytime during the M+CO-designated QAPI time period. *Outpatient chart:* *Medications on the list must be dated or otherwise connectable to the M+CO-designated QAPI time period. If a separate list is not available, or medications on the list are not connectable to the M+CO-designated QAPI time period, review progress notes and consultation reports sequentially, starting from the last visit during the M+CO-designated QAPI time period and progressing backward as needed until the first visit of the M+CO-designated QAPI time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use long-acting nitrates/hydralazine from earlier notes or reports within the M+CO-designated QAPI time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the M+CO-designated QAPI time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization.* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**Long-acting nitrates/ Hydralazine** See list on data collection form	**Long-acting nitrates/Hydralazine** • Long-acting nitrates/ Hydralazine given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
26. OPTIONAL: NYHA class	Before or during the M+CO-designated QAPI time period, what is the New York Heart Association (NYHA) functional classification explicitly documented by a physician/nurse practitioner/ physician assistant in at least one of the last three office visit notes where heart failure is mentioned?	Indicate the New York Heart Association (NYHA) functional classification explicitly documented by a physician/nurse practitioner/physician assistant in at least one of the last three office visit notes where heart failure is mentioned. Use only OUTPATIENT documentation from OUTPATIENT charts to ascertain this information. Do NOT include outpatient documentation that might be incidentally included in an inpatient chart. Documentation must be before or during the M+CO-designated QAPI time period. Refer to the progress notes or consultation reports from the three most recent office visits which mentions heart failure. *If more than one NYHA Class is documented on different dates in the eligible office visit notes, select the most recent class.* *If more than one NYHA Class is documented on the same date within the eligible office visit notes, select the least severe (lowest) class (example - MD writes "Class III" in 5/4/01 office visit note and NP writes "Class II" in 5/4/01 office visit note. Select 'Class II'.).* *If there are only one or two office visit notes before or during the M+CO-designated QAPI time period which mention heart failure, use these visit notes to answer this question.* *Do not attempt to classify heart failure based on patient's symptomatology, physical activity limitations, etc. Documentation must be explicit (example - "Class I").* ***Select one option.*** ➢ **Not collecting -** *Select this option if not gathering this information at this time.* ➢ **Class I** ➢ **Class II** ➢ **Class III** ➢ **Class IV** ➢ **Not documented/Unable to determine** ➢ **Not applicable (Outpatient chart not being used OR heart failure is not mentioned in any office visits before or during the M+CO-designated QAPI time period)**	Outpatient chart: • consultation reports • progress notes	none	none	none

ADDITIONAL M+CO-DEFINED FIELDS *(example - additional indicators such as immunizations)*

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
27. OPTIONAL: M+CO-defined field #1		This element is optional and may be used to collect information to calculate additional quality indicators. Abstract this variable as directed. *If not utilizing this field at this time, enter "X".*				
28. OPTIONAL: M+CO-defined field #2		This element is optional and may be used to collect information to calculate additional quality indicators. Abstract this variable as directed. *If not utilizing this field at this time, enter "X".*				
29. OPTIONAL: M+CO-defined field #3		This element is optional and may be used to collect information to calculate additional quality indicators. Abstract this variable as directed. *If not utilizing this field at this time, enter "X".*				
30. OPTIONAL: M+CO-defined field #4		This element is optional and may be used to collect information to calculate additional quality indicators. Abstract this variable as directed. *If not utilizing this field at this time, enter "X".*				

EP 2001 - LVF AND ACE QIs *(Complete only if option 'Extra payment 2001, no optional QIs' or 'Extra payment 2001 with optional QIs' are among the choices marked in the project question.)*

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
31. LVF assessment	Is there documentation that left ventricular function (LVF) was assessed **anytime** before or during the EP 2001 reporting time period?	Indicate whether there is documentation that LVF was assessed ANYTIME before or during the EP 2001 reporting time period, in any setting. *LVF may be presumed to be previously assessed if one or more of the following is present:* 1) *A formal report from one of the following diagnostic tests: echocardiogram (echo), MUGA scan, or cardiac catheterization - left ventriculogram (LV gram), OR* 2) *Physician/nurse practitioner/physician assistant reference to one of the above diagnostic tests, OR* 3) *Physician/nurse practitioner/physician assistant notation of LVF, either as an ejection fraction (EF) or a narrative qualitative description (Examples - "moderate left ventricular systolic dysfunction", "known systolic dysfunction") without reference to an actual assessment test* *Disregard references to LVF assessment tests when a test was ordered or planned but documentation does not indicate that it was actually **done** before or during the EP 2001 reporting time period* **=> IF NO/UNABLE TO DETERMINE, SKIP TO #33**	Outpatient chart: • consultation reports • diagnostic test reports • problem list • progress notes Inpatient chart: • consultation reports • diagnostic test reports • discharge summary • history & physical	**Echocardiogram (echo)** • 2-D • cardiac ultrasound • Doppler color flow mapping • M-mode **MUGA (multiple gated acquisition scan)** • cardiac blood pool imaging • Cardiolite scan • gated blood pool imaging study • gated heart study • gated ventriculogram • radionuclide ventriculography • Sustamibi scan • technetiuim scan • thallium stress test with LVEF • wall motion study **Cardiac catheterization – Left ventriculogram (LV gram)** • Cardiac angiography - left ventriculogram (LV gram) **Left ventricular function (LVF)** • akinesis • contractility • diastolic dysfunction • diastolic function • diastolic impairment • dyskinesis • ejection fraction (EF) • hypokinesis • left ventricular diastolic dysfunction • left ventricular diastolic function • left ventricular dysfunction (LVD) • left ventricular ejection fraction (LVEF) • left ventricular systolic dysfunction (LVSD) • systolic dysfunction • systolic function • history or finding of left ventricular function (or any of the other above inclusions) described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely",	**Left ventricular function (LVF)** • history or finding of left ventricular function (or any of the other LVF inclusive terms) described as "possible" or "questionable" • left ventricular compliance • left ventricular hypertrophy (LVH)	Billing data: Tests **likely** to represent LVF assessment tests: ICD-9-CM code - 88.72; CPT codes - 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350 (See attachment A for narrative descriptions of these codes) Tests which **possibly** represent LVF assessment tests: ICD-9-CM codes - 88.5x, 92.05; CPT code - 78414 (See attachment A for narrative descriptions of these codes)

				“probable”, or “suggestive of”		

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
32. LVSD	Before or during the EP 2001 reporting time period, is the **most recent** available LVF documented as an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction (LVSD)?	Indicate whether the **most recent** LVF available is documented as an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction (LVSD). Use only documentation before or during the EP 2001 reporting time period to ascertain this information. *Numeric EFs:* ♦ *The value may be documented as a percentage (%), whole number, or decimal. Convert all decimals to percentages (example - 0.40 = 40). Value should be between 5 and 80.* ♦ *If the EF is documented as less than (<) or greater than (>) a given number, use the value one whole number below or above the given number. Examples - "EF < 40%" Use 39%, "EF > 40%" Use 41%* ♦ *If the EF is not documented as a whole number, round fractions to the nearest whole number (examples - 39.5% = 40%, 39.4% = 39%).* ♦ *If both calculated and estimated values are documented on an LVF assessment test report, use the calculated value.* ♦ *If the EF is documented as a range, use the midpoint and consider this an estimated value. Example - LVEF of "35-45%". Use 40% as an estimated EF value.* *LVFs (numeric EFs or narrative descriptions of LVF):* ♦ *When using LVF assessment test reports or physician/nurse practitioner/physician assistant references to test results:* ▪ *If there is more than one test on the same date, use the following priority order in determining the LVF:* 1. *MUGA* 2. *echocardiogram* 3. *cardiac catheterization* 4. *progress notes*	Outpatient chart: • consultation reports • diagnostic test reports • problem list • progress notes Inpatient chart: • consultation reports • diagnostic test reports • discharge summary • history & physical	**Ejection fraction (EF)** • left ventricular ejection fraction (LVEF) **Left ventricular function (LVF)** • akinesis • contractility • diastolic dysfunction • diastolic function • diastolic impairment • dyskinesis • ejection fraction (EF) • hypokinesis • left ventricular diastolic dysfunction • left ventricular diastolic function • left ventricular dysfunction (LVD) • left ventricular ejection fraction (LVEF) • left ventricular systolic dysfunction (LVSD) • systolic dysfunction • systolic function • history or finding of left ventricular function (or any of the other above inclusions) described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of" **Moderate or severe left ventricular systolic dysfunction (LVSD)** • contractility described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • ejection fraction (EF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • hypokinesis described as diffuse, generalized, or global • left ventricular dysfunction (LVD) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not	**Left ventricular function (LVF)** • history or finding of left ventricular function (or any of the other LVF inclusive terms) described as "possible" or "questionable" • left ventricular compliance • left ventricular hypertrophy (LVH) **Moderate or severe left ventricular systolic dysfunction (LVSD)** • history or finding of moderate or severe left ventricular systolic dysfunction (or any of the other moderate or severe LVSD inclusive terms) described as "possible" or "questionable"	none

		▪ *If two or more LVFs are documented in reference to the same test, select 'Yes' if any of the documented LVFs is an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction.* ♦ *When using only physician/nurse practitioner/physician assistant notations of LVF without reference to actual assessment tests:* ▪ *If unable to determine the most recent LVF between two or more LVFs, select 'Yes' if any of the documented LVFs is an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction.* ♦ *If unable to determine the most recent LVF between an LVF from an LVF assessment test report and an LVF noted by a physician/nurse practitioner/physician assistant without reference to an actual assessment test, use the value/description from the LVF assessment test report.*		specified • left ventricular ejection fraction (LVEF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • left ventricular function (LVF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • left ventricular systolic dysfunction (LVSD) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not specified • systolic dysfunction described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not specified • systolic function described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • history or finding of moderate or severe left ventricular systolic dysfunction (or any of the other above inclusions) described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of"		

IMPORTANT NOTES:

- This ACE inhibitor question has been designed to allow M+COs to collect ACEI information on all patients. If ACEI information is to be collected ONLY for patients with LVSD, defined as cases where question #32 = Yes, the option 'Not collecting' should be selected for question #33 when the patient does NOT have documented LVSD (question #31 = No/Unable to determine or question #32 = No/Unable to determine). FOR QUESTION #33, THE OPTION 'NOT COLLECTING' SHOULD NEVER BE USED IN CASES WHERE THE PATIENT HAS LVSD (QUESTION #32 = YES).
- The analyzer accompanying this tool will calculate the ACEI quality indicator only for patients with LVSD. If M+COs wish to evaluate ACEI use in patients without LVSD, they will need to modify the analyzer accordingly.

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
33. ACEI prescribed	Was an ACE inhibitor (ACEI) prescribed anytime during the EP 2001 reporting time period?	Indicate whether an ACEI was prescribed for the patient anytime during the EP 2001 reporting time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the EP 2001 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2001 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2001 reporting time period and progressing backward as needed until the first visit of the EP 2001 reporting time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use ACEIs from earlier notes or reports within the EP 2001 reporting time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the EP 2001 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization.* => If ACEI information is to be collected ONLY for patients with LVSD, defined as cases where question #32 = Yes, select 'Not collecting' when the patient does NOT have documented LVSD (question #31 = No/Unable to determine or question #32 = No/Unable to determine) and **SKIP TO #40** NOTE: THE OPTION 'NOT COLLECTING' SHOULD NEVER BE USED IN CASES WHERE THE PATIENT HAS LVSD (QUESTION #32 = YES). **=> IF YES, SKIP TO #37**	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**ACEIs** See list in question #37 on data collection form	**ACEIs** • ACEIs given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
34. Contraindications to ACEI	If an ACEI was not prescribed during the EP 2001 reporting time period, is there documentation of one or more of the following?	If an ACEI was not prescribed during the EP 2001 reporting time period, indicate whether there is documentation of one or more of the listed conditions. Start with the latest available documentation during the EP 2001 reporting time period and progress backward. These conditions do NOT have to be cited as specific reasons for not prescribing an ACEI. ➢ **a. History of severe ACEI allergy (angioedema, hives, or severe rash) documented anytime before or during the EP 2001 reporting time period** ➢ **b. Aortic stenosis documented anytime before or during the EP 2001 reporting time period** ♦ *If conflicting information exists between diagnostic test reports and other physician sources, use the diagnostic test reports.* ➢ **c. Renal artery stenosis documented anytime before or during the EP 2001 reporting time period** ➢ **d. Serum potassium level > 5.5 mg/dl documented on three or more separate occasions during the EP 2001 reporting time period (excluding lab values measured during an acute care admission, an observation unit stay, or an emergency room visit)** ♦ *If the unit of measure is not documented for a given value, presume the unit of measure is mg/dl.* ♦ *Disregard a serum potassium value when documentation indicates it was measured during an acute care admission, an observation unit stay, or an emergency room visit.* ➢ **e. Serum creatinine level > 3.0 mg/dl documented on three or more separate occasions during the EP**	Outpatient chart: • consultation reports • diagnostic test reports (examples - echocardiogram, cardiac catheterization) • laboratory reports • medication list • problem list • progress notes • vital sign records Inpatient chart: • consultation reports • diagnostic test reports (examples - echocardiogram, cardiac catheterization) • discharge summary • history & physical • progress notes	**ACEIs** See list in question #37 on data collection form **Aortic stenosis (AS)** • aortic stenosis described as "borderline" • history or finding of aortic stenosis described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of" • aortic valve area of < 1.0 square cm **Renal artery stenosis** • renal artery stenosis described as "borderline" • history or finding of renal artery stenosis described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of" **Clinical trials** • CHARM • Elite • Elite II • Elite II with losartan • OVERTURE • ValHeFT	**Aortic stenosis (AS)** • aortic insufficiency only • aortic regurgitation only • aortic stenosis described as "insignificant" or "trivial" • history or finding of aortic stenosis described as "possible" or "questionable" • subaortic stenosis **Renal artery stenosis** • renal artery stenosis described as "insignificant" or "trivial" • history or finding of renal artery stenosis described as "possible" or "questionable"	Billing data: Aortic stenosis: ICD-9-CM codes - 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22 (See attachment A for narrative descriptions of these codes) Renal artery stenosis: ICD-9-CM code - 440.1 (See attachment A for narrative description of this code)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
		2001 reporting time period (excluding lab values measured during an acute care admission, an observation unit stay, or an emergency room visit) ♦ *Creatinine clearance measurements are not synonymous with serum creatinine measurements.* ♦ *If the unit of measure is not documented for a given value, presume the unit of measure is mg/dl.* ♦ *Disregard a serum creatinine value when documentation indicates it was measured during an acute care admission, an observation unit stay, or an emergency room visit.* ➢ **f. Systolic BP < 80 mmHg documented on three or more separate occasions anytime during the EP 2001 reporting time period (excluding blood pressures measured during an acute care admission, an observation unit stay, or an emergency room visit)** ♦ *Disregard patient-reported BPs.* ♦ *If the unit of measure is not documented for a given value, presume the unit of measure is mmHg.* ♦ *Disregard a blood pressure value when documentation indicates it was measured during an acute care admission, an observation unit stay, or an emergency room visit.* ➢ **g. Participation in a clinical trial testing alternatives to ACEIs as first-line heart failure therapy documented during the EP 2001 reporting time period** **=> IF YES, SKIP TO #40**				

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
35. Reason(s) no ACEI prescribed	In documentation before or during the EP 2001 reporting time period, did a physician/nurse practitioner/physician assistant give a reason at anytime for not prescribing an ACEI?	In documentation before or during the EP 2001 reporting time period, indicate whether a physician/nurse practitioner/physician assistant at anytime stated a reason for not prescribing an ACEI. *Examples:* *- "Pt. hypotensive. Will hold off on ACE therapy."* *- "Hx cough with ACEIs."* *- "BPs running low. Won't start ACE inhibitors now."* *- "Acute renal failure. ACEI therapy contraindicated."* *- "Hyperkalemia. Will start ACEIs when K+ drops."* *- "Pt. refuses ACE inhibitor treatment."* *Reasons for not prescribing an ACEI may be explicitly documented (example -"No ACEIs at this time - Creatinine 2.5") or implicitly suggested (example - "High K+ with ACEs in past."). If reasons are not mentioned in the context of ACEIs, do not make inferences.* *If an ACEI is discontinued before the EP 2001 reporting time period and a reason is documented for discontinuing the ACEI (example - "c/o severe cough Will dc Vasotec"), this should be construed as documentation of a reason for not prescribing an ACEI..* *Documentation which indicates consideration (example - "May start ACE therapy after BP stabilizes") should be construed as documentation of a reason for not prescribing an ACEI.* *Include nonspecific documentation of reasons (examples - "Problems with ACEs in past", "ACEIs contraindicated", "Intolerant of ACE inhibitors")* **=> IF NO/UNABLE TO DETERMINE, SKIP TO #40**	Outpatient chart: • consultation reports • medication list • problem list • progress notes Inpatient chart: • consultation reports • discharge summary • history & physical • progress notes	none	none	none
36. OPTIONAL: Other reason - Specify	In documentation before or during the EP 2001 reporting time period, what reason(s) does the physician/nurse practitioner/physician assistant give for not prescribing an ACEI?	Specify the physician/nurse practitioner/ physician assistant reasons documented before or during the EP 2001 reporting time period for not prescribing an ACEI. *If not gathering this information at this time, enter "X".* **=> SKIP TO #40**	Outpatient chart: • consultation reports • medication list • problem list • progress notes Inpatient chart: • consultation reports • discharge summary • history & physical • progress notes	none	none	none

EP 2001 - OPTIONAL QIs *(Complete only if option 'Extra payment 2001 with optional QIs' is among the choices marked in the project question. Follow direction of skip patterns in above section.)*

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
37. OPTIONAL: ACEI name	What is the name of the ACEI prescribed during the EP 2001 reporting time period?	Select the ACEI prescribed during the EP 2001 reporting time period. *If available documentation indicates that two or more different ACEIs were prescribed during the EP 2001 reporting time period, select the most recent one.* *If two or more ACEIs are prescribed concurrently, select the one ACEI by alphabetical order.* *If not gathering this information at this time, select 'Not collecting'.* **=> IF OTHER, COMPLETE #38** **=> IF UNABLE TO DETERMINE OR IF NOT GATHERING THIS INFORMATION AT THIS TIME, SKIP TO #40**	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	none	**ACEIs** • ACEIs given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)
38. OPTIONAL: ACEI - Other name	What is the other ACEI most recently prescribed during the EP 2001 reporting time period?	Specify the name of the other ACEI which, according to available documentation, was most recently prescribed during EP 2001 reporting time period.	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment		**ACEIs** • ACEIs given only during a hospitalization	pharmacy database

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
39. OPTIONAL: ACEI dosage	What is the TOTAL DAILY DOSAGE in mgs. of the ACEI identified in #37 (or #38) during the EP 2001 reporting time period?	Calculate the TOTAL DAILY DOSAGE in mgs. of the ACEI identified in #37 (or #38) during the EP 2001 reporting time period. *If the dosage of the ACEI changed during the EP 2001 reporting time period, calculate the total daily dosage from the most recent dosage documented in the available data sources.* *Do not use decimal points. Round fractions to the nearest whole number (example - captopril 6.25 mg bid. Total daily dosage = 12.50 mg. Enter 13 mg.).* *If unable to determine the total daily dosage of ACEI, enter "0".* *If not gathering this information at this time, enter "X".* *<u>ACEIs combined with other drugs:x</u>* *When combination medications are prescribed, the amount of ACEI these drugs contain is often not readily apparent. Dosages may be expressed as a name alone (example – "Prinzide, 1 tab") or a name followed by a pair of numbers (examples – "Lotrel 2.5/15, 1 tab", "Vaseretic 5-12.5, 2 tabs"). In calculating the ACEI total daily dosage, use the following alphabetized listings to ascertain the amount of the ACEI in ONE tablet of these combination medications:* *Accuretic 10/12.5, Accuretic 10-12.5 = 10 mg (quinapril)* *Accuretic 20/12.5, Accuretic 20-12.5 = 20 mg (quinapril)* *Accuretic 20/25, Accuretic 20-25 = 20 mg (quinapril)* *Capozide 25/15, Capozide 25-15 = 25 mg (captopril)* *Capozide 50/15, Capozide 50-15 = 50 mg (captopril)* *Lexxel = 5 mg (enalapril)* *Lotensin HCT 5/6.25, Lotensin HCT 5-6.25 = 5 mg (benazepril)* *Lotensin HCT 10/12.5, Lotensin HCT 10-12.5 = 10 mg (benazepril)* *Lotensin HCT 20/12.5, Lotensin HCT 20-12.5 = 20 mg (benazepril)* *Lotensin HCT 20/25, Lotensin HCT 20-25 = 20 mg (benazepril)* *Lotrel 2.5/10, Lotrel 2.5-10 = 10 mg (benazepril)* *Lotrel 5/10, Lotrel 5-10 = 10 mg (benazepril)* *Lotrel 5/20, Lotrel 5-20 = 20 mg (benazepril)* *Monopril HCT 10/12.5, Monopril HCT 10-12.5 = 10 mg (fosinopril)* *Monopril HCT 20/12.5, Monopril HCT 20-12.5 = 20 mg (fosinopril)* *Prinzide = 20 mg (lisinopril)* *Tarka 1/240, Tarka 1-240 = 1 mg (trandolapril)* *Tarka 2/180, Tarka 2-180 = 2 mg (trandolapril)* *Tarka 2/240, Tarka 2-240 = 2 mg (trandolapril)* *Tarka 4/240, Tarka 4-240 = 4 mg (trandolapril)* *Teczem = 5 mg (enalapril)* *Uniretic 7.5/12.5, Uniretic 7.5-12.5 = 7.5 mg (moexipril)* *Uniretic 15/25, Uniretic 15-25 = 15 mg (moexipril)* *Vaseretic 5/12.5, Vaseretic 5-12.5 = 5 mg (captopril)* *Vaseretic 10/25, Vaseretic 10-25 = 10 mg (captopril)* *Zestoretic = 20 mg (lisinopril)*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	none	**ACEIs** • ACEIs given only during a hospitalization	pharmacy database

IMPORTANT NOTES:

- The medication prevalence questions in this section have been designed to allow M+COs to collect medication prevalence information on all patients. If this information is to be collected ONLY for patients with LVSD, defined as cases where question #32 = Yes, the option 'Not collecting' should be selected for questions #40 - 44 when the patient does NOT have documented LVSD (question #31 = No/Unable to determine or question #32 = No/Unable to determine). The option 'Not collecting' should also be selected if an M+CO is not collecting this information on any patients.
- The analyzer accompanying this tool will calculate the medication prevalence measures only for patients with LVSD. If M+COs wish to evaluate medication prevalence in patients without LVSD, they will need to modify the analyzer accordingly.

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
40. OPTIONAL: Oral beta blocker prescribed	Was an oral beta blocker prescribed anytime during the EP 2001 reporting time period?	Indicate whether an oral beta blocker was prescribed for the patient anytime during the EP 2001 reporting time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the EP 2001 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2001 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2001 reporting time period and progressing backward as needed until the first visit of the EP 2001 reporting time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use oral beta blockers from earlier notes or reports within the EP 2001 reporting time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the EP 2001 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization.* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**Oral beta blockers** See list on data collection form	**Oral beta blockers** • Oral beta blockers given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
41. OPTIONAL: Digoxin prescribed	Was digoxin prescribed anytime during the EP 2001 reporting time period?	Indicate whether digoxin was prescribed for the patient anytime during the EP 2001 reporting time period. *Outpatient chart:* *If available, use the separate medication list included in the chart.. Medications on the list must be dated or otherwise connectable to the EP 2001 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2001 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2001 reporting time period and progressing backward as needed until the first visit of the EP 2001 reporting time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use digoxin from earlier notes or reports within the EP 2001 reporting time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the EP 2001 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization* *In lieu of documentation of digoxin prescription, if there is documentation that digoxin blood levels were drawn anytime during the EP 2001 reporting time period, digoxin prescription may be inferred.* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • laboratory reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • laboratory reports • nursing admission assessment	**Digoxin** See list on data collection form	**Digoxin** • Digoxin given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)
42. OPTIONAL: Spironolactone prescribed	Was spironolactone prescribed anytime during the EP 2001 reporting time period?	Indicate whether spironolactone was prescribed for the patient anytime during the EP 2001 reporting time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the EP 2001 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2001 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2001 reporting time period and progressing backward as needed until the first visit of the EP 2001 reporting time period. The*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**Spironolactone** • Aldactazide • Aldactone • Spironolactone Plus	**Spirronolactone** • Spironolactone given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
		last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use spironolactone from earlier notes or reports within the EP 2001 reporting time period, regardless of whether they were subsequently discontinued. *Inpatient chart:* *For hospitalizations during the EP 2001 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization* *Select 'Not collecting' if not gathering this information at this time.*				
43. OPTIONAL: ARB prescribed	Was an angiotensin II receptor blocker (ARB) prescribed anytime during the EP 2001 reporting time period?	Indicate whether an ARB was prescribed for the patient anytime during the EP 2001 reporting time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the EP 2001 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2001 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2001 reporting time period and progressing backward as needed until the first visit of the EP 2001 reporting time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use ARBs from earlier notes or reports within the EP 2001 reporting time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the EP 2001 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**ARBs** See list on data collection form	**ARBs** • ARBs given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
44. OPTIONAL: Long-acting nitrates/ hydralazine prescribed	Were BOTH long-acting nitrates AND hydralazine prescribed TOGETHER anytime during the EP 2001 reporting time period?	Indicate whether BOTH long-acting nitrates AND hydralazine were prescribed TOGETHER for the patient anytime during the EP 2001 reporting time period. *Outpatient chart:* *Medications on the list must be dated or otherwise connectable to the EP 2001 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2001 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2001 reporting time period and progressing backward as needed until the first visit of the EP 2001 reporting time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use long-acting nitrates/hydralazine from earlier notes or reports within the EP 2001 reporting time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the EP 2001 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization.* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**Long-acting nitrates/ Hydralazine** See list on data collection form	**Long-acting nitrates/Hydralazine** • Long-acting nitrates/ Hydralazine given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
45. OPTIONAL: NYHA class	Before or during the EP 2001 reporting time period, what is the New York Heart Association (NYHA) functional classification explicitly documented by a physician/nurse practitioner/ physician assistant in at least one of the last three office visit notes where heart failure is mentioned?	Indicate the New York Heart Association (NYHA) functional classification explicitly documented by a physician/nurse practitioner/physician assistant in at least one of the last three office visit notes where heart failure is mentioned. Use only OUTPATIENT documentation from OUTPATIENT charts to ascertain this information. Do NOT include outpatient documentation that might be incidentally included in an inpatient chart. Documentation must be before or during the EP 2001 reporting time period. Refer to the progress notes or consultation reports from the three most recent office visits which mentions heart failure. *If more than one NYHA Class is documented on different dates in the eligible office visit notes, select the most recent class.* *If more than one NYHA Class is documented on the same date within the eligible office visit notes, select the least severe (lowest) class (example - MD writes "Class III" in 5/4/01 office visit note and NP writes "Class II" in 5/4/01 office visit note. Select 'Class II'.).* *If there are only one or two office visit notes before or during the EP 2001 reporting time period which mention heart failure, use these visit notes to answer this question.* *Do not attempt to classify heart failure based on patient's symptomatology, physical activity limitations, etc. Documentation must be explicit (example - "Class I").* ***Select one option.*** ➢ **Not collecting -** *Select this option if not gathering this information at this time.* ➢ **Class I** ➢ **Class II** ➢ **Class III** ➢ **Class IV** ➢ **Not documented/Unable to determine** ➢ **Not applicable (Outpatient chart not being used OR heart failure is not mentioned in any office visits before or during the EP 2001 reporting time period)**	Outpatient chart: • consultation reports • progress notes	none	none	none

EP 2002 - LVF AND ACE QIs *(Complete only if option 'Extra payment 2002, no optional QIs' or 'Extra payment 2002 with optional QIs' are among the choices marked in the project question.)*

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
46. LVF assessment	Is there documentation that left ventricular function (LVF) was assessed **anytime** before or during the EP 2002 reporting time period?	Indicate whether there is documentation that LVF was assessed ANYTIME before or during the EP 2002 reporting time period, in any setting. *LVF may be presumed to be previously assessed if one or more of the following is present:* 1) *A formal report from one of the following diagnostic tests: echocardiogram (echo), MUGA scan, or cardiac catheterization - left ventriculogram (LV gram), OR* 2) *Physician/nurse practitioner/physician assistant reference to one of the above diagnostic tests, OR* 3) *Physician/nurse practitioner/physician assistant notation of LVF, either as an ejection fraction (EF) or a narrative qualitative description (Examples - "moderate left ventricular systolic dysfunction", "known systolic dysfunction") without reference to an actual assessment test* *Disregard references to LVF assessment tests when a test was ordered or planned but documentation does not indicate that it was actually **done** before or during the EP 2002 reporting time period* **=> IF NO/UNABLE TO DETERMINE, SKIP TO**	Outpatient chart: • consultation reports • diagnostic test reports • problem list • progress notes Inpatient chart: • consultation reports • diagnostic test reports • discharge summary • history & physical	**Echocardiogram (echo)** • 2-D • cardiac ultrasound • Doppler color flow mapping • M-mode **MUGA (multiple gated acquisition scan)** • cardiac blood pool imaging • Cardiolite scan • gated blood pool imaging study • gated heart study • gated ventriculogram • radionuclide ventriculography • Sustamibi scan • technetiuim scan • thallium stress test with LVEF • wall motion study **Cardiac catheterization – Left ventriculogram (LV gram)** • Cardiac angiography - left ventriculogram (LV gram) **Left ventricular function (LVF)** • akinesis • contractility • diastolic dysfunction • diastolic function • diastolic impairment • dyskinesis • ejection fraction (EF) • hypokinesis • left ventricular diastolic dysfunction • left ventricular diastolic function • left ventricular dysfunction (LVD) • left ventricular ejection fraction (LVEF) • left ventricular systolic dysfunction (LVSD) • systolic dysfunction • systolic function • history or finding of left ventricular function (or any of the other above inclusions) described using one of the following terms: "consistent with", "diagnostic of", "evidence	**Left ventricular function (LVF)** • history or finding of left ventricular function (or any of the other LVF inclusive terms) described as "possible" or "questionable" • left ventricular compliance • left ventricular hypertrophy (LVH)	Billing data: Tests **likely** to represent LVF assessment tests: ICD-9-CM code - 88.72; CPT codes - 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350 (See attachment A for narrative descriptions of these codes) Tests which **possibly** represent LVF assessment tests: ICD-9-CM codes - 88.5x, 92.05; CPT code - 78414 (See attachment A for narrative descriptions of these codes)

		#48		of", "indicative of", "most likely", "probable", or "suggestive of"		

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
47. LVSD	Before or during the EP 2002 reporting time period, is the **most recent** available LVF documented as an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction (LVSD)?	Indicate whether the **most recent** LVF available is documented as an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction (LVSD). Use only documentation before or during the EP 2002 reporting time period to ascertain this information. *Numeric EFs:* ♦ *The value may be documented as a percentage (%), whole number, or decimal. Convert all decimals to percentages (example - 0.40 = 40). Value should be between 5 and 80.* ♦ *If the EF is documented as less than (<) or greater than (>) a given number, use the value one whole number below or above the given number. Examples - "EF < 40%" Use 39%, "EF > 40%" Use 41%* ♦ *If the EF is not documented as a whole number, round fractions to the nearest whole number (examples - 39.5% = 40%, 39.4% = 39%).* ♦ *If both calculated and estimated values are documented on an LVF assessment test report, use the calculated value.* ♦ *If the EF is documented as a range, use the midpoint and consider this an estimated value. Example - LVEF of "35-45%". Use 40% as an estimated EF value.* *LVFs (numeric EFs or narrative descriptions of LVF):* ♦ *When using LVF assessment test reports or physician/nurse practitioner/physician assistant references to test results:* ▪ *If there is more than one test on the same date, use the following priority order in determining the LVF:* 1. *MUGA* 2. *echocardiogram* 3. *cardiac catheterization* 4. *progress notes*	Outpatient chart: • consultation reports • diagnostic test reports • problem list • progress notes Inpatient chart: • consultation reports • diagnostic test reports • discharge summary • history & physical	**Ejection fraction (EF)** • left ventricular ejection fraction (LVEF) **Left ventricular function (LVF)** • akinesis • contractility • diastolic dysfunction • diastolic function • diastolic impairment • dyskinesis • ejection fraction (EF) • hypokinesis • left ventricular diastolic dysfunction • left ventricular diastolic function • left ventricular dysfunction (LVD) • left ventricular ejection fraction (LVEF) • left ventricular systolic dysfunction (LVSD) • systolic dysfunction • systolic function • history or finding of left ventricular function (or any of the other above inclusions) described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of" **Moderate or severe left ventricular systolic dysfunction (LVSD)** • contractility described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • ejection fraction (EF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • hypokinesis described as diffuse, generalized, or global • left ventricular dysfunction (LVD) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not	**Left ventricular function (LVF)** • history or finding of left ventricular function (or any of the other LVF inclusive terms) described as "possible" or "questionable" • left ventricular compliance • left ventricular hypertrophy (LVH) **Moderate or severe left ventricular systolic dysfunction (LVSD)** • history or finding of moderate or severe left ventricular systolic dysfunction (or any of the other moderate or severe LVSD inclusive terms) described as "possible" or "questionable"	none

		▪ *If two or more LVFs are documented in reference to the same test, select 'Yes' if any of the documented LVFs is an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction.* ♦ *When using only physician/nurse practitioner/physician assistant notations of LVF without reference to actual assessment tests:* ▪ *If unable to determine the most recent LVF between two or more LVFs, select 'Yes' if any of the documented LVFs is an EF < 40% or a qualitative description consistent with moderate or severe left ventricular systolic dysfunction.* ♦ *If unable to determine the most recent LVF between an LVF from an LVF assessment test report and an LVF noted by a physician/nurse practitioner/physician assistant without reference to an actual assessment test, use the value/description from the LVF assessment test report.*		specified • left ventricular ejection fraction (LVEF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • left ventricular function (LVF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • left ventricular systolic dysfunction (LVSD) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not specified • systolic dysfunction described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not specified • systolic function described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low • history or finding of moderate or severe left ventricular systolic dysfunction (or any of the other above inclusions) described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of"		

IMPORTANT NOTES:

- This ACE inhibitor question has been designed to allow M+COs to collect ACEI information on all patients. If ACEI information is to be collected ONLY for patients with LVSD, defined as cases where question #47 = Yes, the option 'Not collecting' should be selected for question #48 when the patient does NOT have documented LVSD (question #46 = No/Unable to determine or question #47 = No/Unable to determine). FOR QUESTION #48, THE OPTION 'NOT COLLECTING' SHOULD NEVER BE USED IN CASES WHERE THE PATIENT HAS LVSD (QUESTION #47 = YES).
- The analyzer accompanying this tool will calculate the ACEI quality indicator only for patients with LVSD. If M+COs wish to evaluate ACEI use in patients without LVSD, they will need to modify the analyzer accordingly.

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
48. ACEI prescribed	Was an ACE inhibitor (ACEI) prescribed anytime during the EP 2002 reporting time period?	Indicate whether an ACEI was prescribed for the patient anytime during the EP 2002 reporting time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the EP 2002 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2002 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2002 reporting time period and progressing backward as needed until the first visit of the EP 2002 reporting time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use ACEIs from earlier notes or reports within the EP 2002 reporting time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the EP 2002 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization.* => If ACEI information is to be collected ONLY for patients with LVSD, defined as cases where question #47 = Yes, select 'Not collecting' when the patient does NOT have documented LVSD (question #46 = No/Unable to determine or question #47 = No/Unable to determine) and **SKIP TO #55** NOTE: THE OPTION 'NOT COLLECTING' SHOULD NEVER BE USED IN CASES WHERE THE PATIENT HAS LVSD (QUESTION #47 = YES). **=> IF YES, SKIP TO #52**	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**ACEIs** See list in question #52 on data collection form	**ACEIs** • ACEIs given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
49. Contraindications to ACEI	If an ACEI was not prescribed during the EP 2002 reporting time period, is there documentation of one or more of the following?	If an ACEI was not prescribed during the EP 2002 reporting time period, indicate whether there is documentation of one or more of the listed conditions. Start with the latest available documentation during the EP 2002 reporting time period and progress backward. These conditions do NOT have to be cited as specific reasons for not prescribing an ACEI. ➢ **a. History of severe ACEI allergy (angioedema, hives, or severe rash) documented anytime before or during the EP 2002 reporting time period** ➢ **b. Aortic stenosis documented anytime before or during the EP 2002 reporting time period** ♦ *If conflicting information exists between diagnostic test reports and other physician sources, use the diagnostic test reports.* ➢ **c. Renal artery stenosis documented anytime before or during the EP 2002 reporting time period** ➢ **d. Serum potassium level > 5.5 mg/dl documented on three or more separate occasions during the EP 2002 reporting time period (excluding lab values measured during an acute care admission, an observation unit stay, or an emergency room visit)** ♦ *If the unit of measure is not documented for a given value, presume the unit of measure is mg/dl.* ♦ *Disregard a serum potassium value when documentation indicates it was measured during an acute care admission, an observation unit stay, or an emergency room visit.* ➢ **e. Serum creatinine level > 3.0 mg/dl documented on three or more separate occasions during the EP**	Outpatient chart: • consultation reports • diagnostic test reports (examples - echocardiogram, cardiac catheterization) • laboratory reports • medication list • problem list • progress notes • vital sign records Inpatient chart: • consultation reports • diagnostic test reports (examples - echocardiogram, cardiac catheterization) • discharge summary • history & physical • progress notes	**ACEIs** See list in question #52 on data collection form **Aortic stenosis (AS)** • aortic stenosis described as "borderline" • history or finding of aortic stenosis described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of" • aortic valve area of < 1.0 square cm **Renal artery stenosis** • renal artery stenosis described as "borderline" • history or finding of renal artery stenosis described using one of the following terms: "consistent with", "diagnostic of", "evidence of", "indicative of", "most likely", "probable", or "suggestive of" **Clinical trials** • CHARM • Elite • Elite II • Elite II with losartan • OVERTURE • ValHeFT	**Aortic stenosis (AS)** • aortic insufficiency only • aortic regurgitation only • aortic stenosis described as "insignificant" or "trivial" • history or finding of aortic stenosis described as "possible" or "questionable" • subaortic stenosis **Renal artery stenosis** • renal artery stenosis described as "insignificant" or "trivial" • history or finding of renal artery stenosis described as "possible" or "questionable"	Billing data: Aortic stenosis: ICD-9-CM codes - 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22 (See attachment A for narrative descriptions of these codes) Renal artery stenosis: ICD-9-CM code - 440.1 (See attachment A for narrative description of this code)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
		2002 reporting time period (excluding lab values measured during an acute care admission, an observation unit stay, or an emergency room visit) ♦ *Creatinine clearance measurements are not synonymous with serum creatinine measurements.* ♦ *If the unit of measure is not documented for a given value, presume the unit of measure is mg/dl.* ♦ *Disregard a serum creatinine value when documentation indicates it was measured during an acute care admission, an observation unit stay, or an emergency room visit.* ➢ **f. Systolic BP < 80 mmHg documented on three or more separate occasions anytime during the EP 2002 reporting time period (excluding blood pressures measured during an acute care admission, an observation unit stay, or an emergency room visit)** ♦ *Disregard patient-reported BPs.* ♦ *If the unit of measure is not documented for a given value, presume the unit of measure is mmHg.* ♦ *Disregard a blood pressure value when documentation indicates it was measured during an acute care admission, an observation unit stay, or an emergency room visit.* ➢ **g. Participation in a clinical trial testing alternatives to ACEIs as first-line heart failure therapy documented during the EP 2002 reporting time period** **=> IF YES, SKIP TO #55**				

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
50. Reason(s) no ACEI prescribed	In documentation before or during the EP 2002 reporting time period, did a physician/nurse practitioner/physician assistant give a reason at anytime for not prescribing an ACEI?	In documentation before or during the EP 2002 reporting time period, indicate whether a physician/nurse practitioner/physician assistant at anytime stated a reason for not prescribing an ACEI. *Examples:* *- "Pt. hypotensive. Will hold off on ACE therapy."* *- "Hx cough with ACEIs."* *- "BPs running low. Won't start ACE inhibitors now."* *- "Acute renal failure. ACEI therapy contraindicated."* *- "Hyperkalemia. Will start ACEIs when K+ drops."* *- "Pt. refuses ACE inhibitor treatment."* *Reasons for not prescribing an ACEI may be explicitly documented (example -"No ACEIs at this time - Creatinine 2.5") or implicitly suggested (example - "High K+ with ACEs in past."). If reasons are not mentioned in the context of ACEIs, do not make inferences.* *If an ACEI is discontinued before the EP 2002 reporting time period and a reason is documented for discontinuing the ACEI (example - "c/o severe cough Will dc Vasotec"), this should be construed as documentation of a reason for not prescribing an ACEI..* *Documentation which indicates consideration (example - "May start ACE therapy after BP stabilizes") should be construed as documentation of a reason for not prescribing an ACEI.* *Include nonspecific documentation of reasons (examples - "Problems with ACEs in past", "ACEIs contraindicated", "Intolerant of ACE inhibitors")* **=> IF NO/UNABLE TO DETERMINE, SKIP TO #55**	Outpatient chart: • consultation reports • medication list • problem list • progress notes Inpatient chart: • consultation reports • discharge summary • history & physical • progress notes	none	none	none
51. OPTIONAL: Other reason - Specify	In documentation before or during the EP 2002 reporting time period, what reason(s) does the physician/nurse practitioner/physician assistant give for not prescribing an ACEI?	Specify the physician/nurse practitioner/ physician assistant reasons documented before or during the EP 2002 reporting time period for not prescribing an ACEI. *If not gathering this information at this time, enter "X".* **=> SKIP TO #55**	Outpatient chart: • consultation reports • medication list • problem list • progress notes Inpatient chart: • consultation reports • discharge summary • history & physical • progress notes	none	none	none

EP 2002 - OPTIONAL QIs *(Complete only if option 'Extra payment 2002 with optional QIs' is among the choices marked in the project question. Follow direction of skip patterns in above section.)*

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
52. OPTIONAL: ACEI name	What is the name of the ACEI prescribed during the EP 2002 reporting time period?	Select the ACEI prescribed during the EP 2002 reporting time period. *If available documentation indicates that two or more different ACEIs were prescribed during the EP 2002 reporting time period, select the most recent one.* *If two or more ACEIs are prescribed concurrently, select the one ACEI by alphabetical order.* *If not gathering this information at this time, select 'Not collecting'.* **=> IF OTHER, COMPLETE #53** **=> IF UNABLE TO DETERMINE OR IF NOT GATHERING THIS INFORMATION AT THIS TIME, SKIP TO #55**	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	none	**ACEIs** • ACEIs given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)
53. OPTIONAL: ACEI - Other name	What is the other ACEI most recently prescribed during the EP 2002 reporting time period?	Specify the name of the other ACEI which, according to available documentation, was most recently prescribed during EP 2002 reporting time period.	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment		**ACEIs** • ACEIs given only during a hospitalization	pharmacy database

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
54. OPTIONAL: ACEI dosage	What is the TOTAL DAILY DOSAGE in mgs. of the ACEI identified in #52 (or #53) during the EP 2002 reporting time period?	Calculate the TOTAL DAILY DOSAGE in mgs. of the ACEI identified in #52 (or #53) during the EP 2002 reporting time period. *If the dosage of the ACEI changed during the EP 2002 reporting time period, calculate the total daily dosage from the most recent dosage documented in the available data sources.* *Do not use decimal points. Round fractions to the nearest whole number (example - captopril 6.25 mg bid. Total daily dosage = 12.50 mg. Enter 13 mg.).* *If unable to determine the total daily dosage of ACEI, enter "0".* *If not gathering this information at this time, enter "X".* *<u>ACEIs combined with other drugs:x</u>* *When combination medications are prescribed, the amount of ACEI these drugs contain is often not readily apparent. Dosages may be expressed as a name alone (example – "Prinzide, 1 tab") or a name followed by a pair of numbers (examples – "Lotrel 2.5/15, 1 tab", "Vaseretic 5-12.5, 2 tabs"). In calculating the ACEI total daily dosage, use the following alphabetized listings to ascertain the amount of the ACEI in ONE tablet of these combination medications:* *Accuretic 10/12.5, Accuretic 10-12.5 = 10 mg (quinapril)* *Accuretic 20/12.5, Accuretic 20-12.5 = 20 mg (quinapril)* *Accuretic 20/25, Accuretic 20-25 = 20 mg (quinapril)* *Capozide 25/15, Capozide 25-15 = 25 mg (captopril)* *Capozide 50/15, Capozide 50-15 = 50 mg (captopril)* *Lexxel = 5 mg (enalapril)* *Lotensin HCT 5/6.25, Lotensin HCT 5-6.25 = 5 mg (benazepril)* *Lotensin HCT 10/12.5, Lotensin HCT 10-12.5 = 10 mg (benazepril)* *Lotensin HCT 20/12.5, Lotensin HCT 20-12.5 = 20 mg (benazepril)* *Lotensin HCT 20/25, Lotensin HCT 20-25 = 20 mg (benazepril)* *Lotrel 2.5/10, Lotrel 2.5-10 = 10 mg (benazepril)* *Lotrel 5/10, Lotrel 5-10 = 10 mg (benazepril)* *Lotrel 5/20, Lotrel 5-20 = 20 mg (benazepril)* *Monopril HCT 10/12.5, Monopril HCT 10-12.5 = 10 mg (fosinopril)* *Monopril HCT 20/12.5, Monopril HCT 20-12.5 = 20 mg (fosinopril)* *Prinzide = 20 mg (lisinopril)* *Tarka 1/240, Tarka 1-240 = 1 mg (trandolapril)* *Tarka 2/180, Tarka 2-180 = 2 mg (trandolapril)* *Tarka 2/240, Tarka 2-240 = 2 mg (trandolapril)* *Tarka 4/240, Tarka 4-240 = 4 mg (trandolapril)* *Teczem = 5 mg (enalapril)* *Uniretic 7.5/12.5, Uniretic 7.5-12.5 = 7.5 mg (moexipril)* *Uniretic 15/25, Uniretic 15-25 = 15 mg (moexipril)* *Vaseretic 5/12.5, Vaseretic 5-12.5 = 5 mg (captopril)* *Vaseretic 10/25, Vaseretic 10-25 = 10 mg (captopril)* *Zestoretic = 20 mg (lisinopril)*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	none	**ACEIs** • ACEIs given only during a hospitalization	pharmacy database

IMPORTANT NOTES:

- The medication prevalence questions in this section have been designed to allow M+COs to collect medication prevalence information on all patients. If this information is to be collected ONLY for patients with LVSD, defined as cases where question #47 = Yes, the option 'Not collecting' should be selected for questions #55 - 59 when the patient does NOT have documented LVSD (question #46 = No/Unable to determine or question #47 = No/Unable to determine). The option 'Not collecting' should also be selected if an M+CO is not collecting this information on any patients.
- The analyzer accompanying this tool will calculate the medication prevalence measures only for patients with LVSD. If M+COs wish to evaluate medication prevalence in patients without LVSD, they will need to modify the analyzer accordingly.

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
55. OPTIONAL: Oral beta blocker prescribed	Was an oral beta blocker prescribed anytime during the EP 2002 reporting time period?	Indicate whether an oral beta blocker was prescribed for the patient anytime during the EP 2002 reporting time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the EP 2002 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2002 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2002 reporting time period and progressing backward as needed until the first visit of the EP 2002 reporting time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use oral beta blockers from earlier notes or reports within the EP 2002 reporting time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the EP 2002 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization.* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**Oral beta blockers** See list on data collection form	**Oral beta blockers** • Oral beta blockers given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
56. OPTIONAL: Digoxin prescribed	Was digoxin prescribed anytime during the EP 2002 reporting time period?	Indicate whether digoxin was prescribed for the patient anytime during the EP 2002 reporting time period. *Outpatient chart:* *If available, use the separate medication list included in the chart.. Medications on the list must be dated or otherwise connectable to the EP 2002 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2002 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2002 reporting time period and progressing backward as needed until the first visit of the EP 2002 reporting time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use digoxin from earlier notes or reports within the EP 2002 reporting time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the EP 2002 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization* *In lieu of documentation of digoxin prescription, if there is documentation that digoxin blood levels were drawn anytime during the EP 2002 reporting time period, digoxin prescription may be inferred.* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • laboratory reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • laboratory reports • nursing admission assessment	**Digoxin** See list on data collection form	**Digoxin** • Digoxin given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)
57. OPTIONAL: Spironolactone prescribed	Was spironolactone prescribed anytime during the EP 2002 reporting time period?	Indicate whether spironolactone was prescribed for the patient anytime during the EP 2002 reporting time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the EP 2002 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2002 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2002 reporting time period and progressing backward as needed until the first visit of the EP 2002 reporting time period. The last listing of medications in the progress notes or consultation*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**Spironolactone** • Aldactazide • Aldactone • Spironolactone Plus	**Spirronolactone** • Spironolactone given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
		reports may not always be complete. In these cases, use spironolactone from earlier notes or reports within the EP 2002 reporting time period, regardless of whether they were subsequently discontinued. *Inpatient chart:* *For hospitalizations during the EP 2002 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization* *Select 'Not collecting' if not gathering this information at this time.*				
58. OPTIONAL: ARB prescribed	Was an angiotensin II receptor blocker (ARB) prescribed anytime during the EP 2002 reporting time period?	Indicate whether an ARB was prescribed for the patient anytime during the EP 2002 reporting time period. *Outpatient chart:* *If available, use the separate medication list included in the chart. Medications on the list must be dated or otherwise connectable to the EP 2002 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2002 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2002 reporting time period and progressing backward as needed until the first visit of the EP 2002 reporting time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use ARBs from earlier notes or reports within the EP 2002 reporting time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the EP 2002 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**ARBs** See list on data collection form	**ARBs** • ARBs given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
59. OPTIONAL: Long-acting nitrates/ hydralazine prescribed	Were BOTH long-acting nitrates AND hydralazine prescribed TOGETHER anytime during the EP 2002 reporting time period?	Indicate whether BOTH long-acting nitrates AND hydralazine were prescribed TOGETHER for the patient anytime during the EP 2002 reporting time period. *Outpatient chart:* *Medications on the list must be dated or otherwise connectable to the EP 2002 reporting time period. If a separate list is not available, or medications on the list are not connectable to the EP 2002 reporting time period, review progress notes and consultation reports sequentially, starting from the last visit during the EP 2002 reporting time period and progressing backward as needed until the first visit of the EP 2002 reporting time period. The last listing of medications in the progress notes or consultation reports may not always be complete. In these cases, use long-acting nitrates/hydralazine from earlier notes or reports within the EP 2002 reporting time period, regardless of whether they were subsequently discontinued.* *Inpatient chart:* *For hospitalizations during the EP 2002 reporting time period, admission medication and discharge medication lists should be used. Disregard medications given only during the hospitalization.* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • medication list • progress notes Inpatient chart: • discharge instruction sheet • discharge summary • history & physical • nursing admission assessment	**Long-acting nitrates/ Hydralazine** See list on data collection form	**Long-acting nitrates/Hydralazine** • Long-acting nitrates/ Hydralazine given only during a hospitalization	pharmacy database (See mcohf_ndc_list.xls for ndc listings)

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
60. OPTIONAL: NYHA class	Before or during the EP 2002 reporting time period, what is the New York Heart Association (NYHA) functional classification explicitly documented by a physician/nurse practitioner/ physician assistant in at least one of the last three office visit notes where heart failure is mentioned?	Indicate the New York Heart Association (NYHA) functional classification explicitly documented by a physician/nurse practitioner/physician assistant in at least one of the last three office visit notes where heart failure is mentioned. Use only OUTPATIENT documentation from OUTPATIENT charts to ascertain this information. Do NOT include outpatient documentation that might be incidentally included in an inpatient chart. Documentation must be before or during the EP 2002 reporting time period. Refer to the progress notes or consultation reports from the three most recent office visits which mentions heart failure. *If more than one NYHA Class is documented on different dates in the eligible office visit notes, select the most recent class.* *If more than one NYHA Class is documented on the same date within the eligible office visit notes, select the least severe (lowest) class (example - MD writes "Class III" in 5/4/01 office visit note and NP writes "Class II" in 5/4/01 office visit note. Select 'Class II'.).* *If there are only one or two office visit notes before or during the EP 2002 reporting time period which mention heart failure, use these visit notes to answer this question.* *Do not attempt to classify heart failure based on patient's symptomatology, physical activity limitations, etc. Documentation must be explicit (example - "Class I").* ***Select one option.*** ➢ **Not collecting -** *Select this option if not gathering this information at this time.* ➢ **Class I** ➢ **Class II** ➢ **Class III** ➢ **Class IV** ➢ **Not documented/Unable to determine** ➢ **Not applicable (Outpatient chart not being used OR heart failure is not mentioned in any office visits before or during the EP 2002 reporting time period)**	Outpatient chart: • consultation reports • progress notes	none	none	none

DEMOGRAPHIC ADDITIONAL INFORMATION/OPTIONAL

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
61. OPTIONAL: Race	What is the patient's race?	Indicate the patient's race. ***Select one option.*** ➢ **Not collecting** - *Select this option if not gathering this information at this time.* ➢ **Caucasian** ➢ **African-American** ➢ **American Indian/Alaska Native** ➢ **Asian** ➢ **Native Hawaiian/Pacific Islander** ➢ **Multiracial** ➢ **Other** ➢ **Unable to determine** - *Examples - race not documented, conflicting documentation of race, documentation only states "Hispanic"*	Outpatient chart: • consultation reports • face sheet • progress notes Inpatient chart: • discharge summary • face sheet • history & physical	**Caucasian** • Iranian • Middle Easterner • White (W, Whi) **African-American** • Black (B) • Haitian • Negro **American Indian/Alaska Native** • Any recognized tribal entity in North, South, or Central America • Native American **Asian** • Asian-American • Cambodian • Chinese • Far East • Filipino • Japanese • Korean • Malaysian • Pakistani • South East Asian • Thailand • Vietnamese **Native Hawaiian/Pacific Islander** • Guam • Other Pacific Islands • Samoan	none	none

DATA ELEMENT	QUESTION	CHART ABSTRACTION INSTRUCTIONS	RECOMMENDED CHART LOCATIONS	INCLUSIONS	EXCLUSIONS	RECOMMENDED DATA SOURCES OTHER THAN CHARTS
62. OPTIONAL: Hispanic ethnicity	Is the patient Hispanic?	Indicate whether the patient is of Hispanic ethnicity. *Hispanic ethnicity includes documentation that the patient is Hispanic or is Hispanic of mixed ethnicity (example - "White-Hispanic").* *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • face sheet • progress notes Inpatient chart: • discharge summary • face sheet • history & physical	**Hispanic** • Black-Hispanic • Central American • Chicano • Cuban • H • Latin American • Latino/Latina • Mexican • Mexican-American • Puerto Rican • South American • Spanish • White-Hispanic	none	none
63. OPTIONAL: Gender	What is the patient's gender?	Indicate the patient's gender. *Select 'Not collecting' if not gathering this information at this time.*	Outpatient chart: • consultation reports • face sheet • progress notes Inpatient chart: • discharge summary • face sheet • history & physical	none	none	none

ICD-9-CM and CPT code descriptions

Condition/ Procedure	ICD-9-CM Code (year 2001)	CPT Code (year 2001)	Narrative Description
Heart failure	402.01		Hypertensive heart disease, malignant, with congestive heart failure
	402.11		Hypertensive heart disease, benign, with congestive heart failure
	402.91		Hypertensive heart disease, unspecified, with congestive heart failure
	404.01		Hypertensive heart and renal disease, malignant, with congestive heart failure
	404.11		Hypertensive heart and renal disease, benign, with congestive heart failure
	404.91		Hypertensive heart and renal disease, unspecified, with congestive heart failure
	428.x		Congestive heart failure Left heart failure Heart failure, unspecified
Renal dialysis	V56.0		Extracorporeal dialysis
	V56.8		Other dialysis
	39.95		Hemodialysis
	54.98		Peritoneal dialysis
		90935	Hemodialysis procedure with single physician evaluation
		90937	Hemodialysis procedure with single physician evaluation, with or without substantial revision of dialysis
		90940	Hemodialysis access flow study to determine blood flow in grafts and av fistulae by an indicatior dilution method
		90945	Dialysis procedure other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continous renal replacement therapies), with single physician evaluation
		90947	Dialysis procedure other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continous renal replacement therapies), with repeated physician evaluation, with or without substantial revision of dialysis prescription
		90989	Dialysis training
		90993	Dialysis training
Aortic stenosis	395.0		Rheumatic aortic stenosis
	395.2		Rheumatic aortic stenosis with insufficiency
	396.0		Mitral valve stenosis and aortic valve stenosis
	396.2		Mitral valve insufficiency and aortic valve stenosis
	396.8		Multiple involvement of mitral and aortic valves
	424.1		Aortic valve disorders
	425.1		Hypertrophic obstructive cardiomyopathy
	747.22		Atresia and stenosis of aorta
Renal artery stenosis	440.1		Atherosclerosis of renal artery

Procedure	ICD-9-CM	CPT Code	Narrative Description

	Code (year 2001)	(year 2001)	
Tests **likely** to represent LVF assessment tests	88.72		Diagnostic ultrasound of heart
		78468	Myocardial imaging, infarct avid, planar; with EF by first pass technique
		78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus EF, with or without additional quantitative processing
		78473	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus EF, at rest and stress (exercise and/or pharmacologic), with or without additional quantification
		78480	Myocardial perfusion study with EF
		78481	Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or stress (exercise and/or pharmacologic), wall motion study plus EF, with or without quantification
		78483	Cardiac blood pool imaging, (planar), first pass technique; multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study plus EF, with or without quantification
		78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus EF, with or without quantitative processing
		93303	Transthoracic echo for congenital cardiac anomalies; complete
		93304	Transthoracic echo for congenital cardiac anomalies; follow-up or limited study
		93307	Echo, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete
		93308	Echo, transthoracic, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study
		93312	Echo, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
		93314	Echo, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only
		93315	Transesophageal echo for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
		93317	Transesophageal echo for congenital cardiac anomalies; image acquisition, interpretation and report only
		93350	Echo, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report
Tests which **possibly** represent LVF assessment tests	88.5x		Angiocardiography, not otherwise specified Angiocardiography of venae cavae Angiocardiography of right heart structures Angiocardiography of left heart structures Combined right and left heart angiocardiography Coronary arteriography using a single catheter Coronary arteriography using two catheters Other and unspecified coronary arteriography Negative-contrast cardiac roentgenography
	92.05		Cardiovascular and hematopoietic scan and radioisotope function study
		78414	Determination of central c-v hemodynamics (non-imaging) (e.g., EF with probe technique) with or without pharmacologic intervention or exercise, single or multiple determinations

Outpatient Physician Encounter CPT Codes - Years 2000 and 2001

CPT code	Narrative Description
99201	New patient: Office or other outpatient visit
99202	New patient: Office or other outpatient visit
99203	New patient: Office or other outpatient visit
99204	New patient: Office or other outpatient visit
99205	New patient: Office or other outpatient visit
99211	Established patient: Office or other outpatient visit
99212	Established patient: Office or other outpatient visit
99213	Established patient: Office or other outpatient visit
99214	Established patient: Office or other outpatient visit
99215	Established patient: Office or other outpatient visit
99241	New or established patient: Office consultation
99242	New or established patient: Office consultation
99243	New or established patient: Office consultation
99244	New or established patient: Office consultation
99245	New or established patient: Office consultation
99271	New or established patient: Confirmatory consultation
99272	New or established patient: Confirmatory consultation
99273	New or established patient: Confirmatory consultation
99274	New or established patient: Confirmatory consultation
99275	New or established patient: Confirmatory consultation
99281	New or established patient: Emergency department visit
99282	New or established patient: Emergency department visit
99283	New or established patient: Emergency department visit
99284	New or established patient: Emergency department visit
99285	New or established patient: Emergency department visit
99301	New or established patient: Evaluation and management (nursing facility)
99302	New or established patient: Evaluation and management (nursing facility)
99303	New or established patient: Evaluation and management (nursing facility)
99311	New or established patient: Subsequent nursing facility care
99312	New or established patient: Subsequent nursing facility care
99313	New or established patient: Subsequent nursing facility care
99315	Nursing facility discharge services
99316	Nursing facility discharge services
99321	New patient: Domiciliary or rest home visit
99322	New patient: Domiciliary or rest home visit
99323	New patient: Domiciliary or rest home visit
99331	Established patient: Domiciliary or rest home visit
99332	Established patient: Domiciliary or rest home visit
99333	Established patient: Domiciliary or rest home visit
99341	New patient: Home visit
99342	New patient: Home visit
99343	New patient: Home visit
99344	New patient: Home visit
99345	New patient: Home visit
99347	Established patient: Home visit
99348	Established patient: Home visit
99349	Established patient: Home visit
99350	Established patient: Home visit
99381	New patient: Initial preventive medicine, age < 1 y
99382	New patient: Initial preventive medicine, age 1 - 4 y
99383	New patient: Initial preventive medicine, age 5 - 11 y
99384	New patient: Initial preventive medicine, age 12 - 17 y
99385	New patient: Initial preventive medicine, age 18 - 39 y
99386	New patient: Initial preventive medicine, age 40 - 64 y
99387	New patient: Initial preventive medicine, age > 65 y

CPT code	Narrative Description
99391	Established patient: Periodic preventive medicine, age < 1 y
99392	Established patient: Periodic preventive medicine, age 1 - 4 y
99393	Established patient: Periodic preventive medicine, age 5 - 11 y
99394	Established patient: Periodic preventive medicine, age 12 - 17 y
99395	Established patient: Periodic preventive medicine, age 18 - 39 y
99396	Established patient: Periodic preventive medicine, age 40 - 64 y
99397	Established patient: Periodic preventive medicine, age > 65 y
99401	Preventive medicine counseling
99402	Preventive medicine counseling
99403	Preventive medicine counseling
99404	Preventive medicine counseling
99411	Preventive medicine counseling
99412	Preventive medicine counseling
99420	Administration and interpretation of health risk assessment instrument
99429	Unlisted preventive medicine service